

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

12451

12475

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY <b>Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit Rural</b>	
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Hawley</b> Last <b>Abrahams</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 19, 1873</b>
9. AGE (In years last birthday) <b>86</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>10</b> Hours <b>4</b> Min. <b>59</b>	11. IF UNDER 24 HRS. Months <b>4</b> Days <b>10</b> Hours <b>4</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Cornelius S. Abrahams</b>		14. MOTHER'S MAIDEN NAME <b>Clara D. Vanneman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Informant</b>	
17. ADDRESS <b>Cornelia S. Abrahams, Port Deposit, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage - 331X</b> DUE TO (b) <b>Paralysis Left Side - Antonio Salomon - Cerebral Sclerosis</b> DUE TO (c) <b>Myocarditis</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>4 months 10 yrs</b>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocarditis</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22c. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
23. I certify that I attended the deceased from <b>June 20, 1959</b> to <b>November 17, 1959</b> that I last saw the deceased alive on <b>Nov-17-</b> 19 <b>59</b> , and that death occurred at <b>6:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clarence I. Benson</b> M.D.		ADDRESS (Street, city or town, state) <b>Port Deposit, Md.</b> DATE SIGNED <b>11/19/59</b>	
PHYSICIAN'S NAME (Type) <b>Clarence I. Benson, M.D.</b>			
24a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE THEREOF <b>11-21- 1959</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>
25. FUNERAL DIRECTOR'S SIGNATURE <b>W. A. Patterson, Son</b>		26. ADDRESS <b>Perryville, Md</b>	
27a. REC'D BY REGISTRAR <b>NOV 23 '59</b>		27b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ESTIMATES OF DEATH

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Actual

Estimated

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Ratio

Ratio

Ratio

Ratio

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CERTIFICATE OF DEATH

12453

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST RI</u>				c. LENGTH OF STAY IN 1b <u>41</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X NORTH EAST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CRESS A. BEAMER</u>				4. DATE OF DEATH Month Day Year <u>11 19 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 22 1887</u>	
9. AGE (In years lost birthday) yrs. <u>79</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>TENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>PETER M BEAMER</u>		14. MOTHER'S MAIDEN NAME <u>JANE WARREN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>220-34-7071</u>		17. INFORMANT <u>Mrs Olive Black</u>		Address <u>Elkton RD 5 Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> <u>1533</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral edema of sigmoid</u> DUE TO (c) <u>2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Feb 11 1959</u> to <u>Nov 19 1959</u> , that I last saw the deceased alive on <u>Nov 19 1959</u> , and that death occurred at <u>4:10</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>CECIL CO. Md</u>		DATE SIGNED <u>Nov 24 1959</u>	
ACTUAL SIGNATURE <u>G. C. Holcomb</u>		PHYSICIAN'S NAME (Type) <u>G. C. Holcomb</u>		M.D. <u>Oxford Pa</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
22b. DATE THEREOF <u>11-22-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BAY VIEW METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>BAY VIEW, CECIL CO. Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>	
ADDRESS <u>North East. Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12452

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Cecil</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>237 West Main</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <u>Harriet R. Bernard</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>11 3 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <span style="float: right;">8. DATE OF BIRTH</span> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/> <u>July 4, 1877</u>			
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>6</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John P. Winchester</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Martin</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Mrs Edward T. Williams</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of the base of skull neck of the left femur</u> DUE TO (b) <u>900.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairway</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2:30</u> p. m. <u>11-3 1959</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Elkton Cecil Maryland</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11-3-1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-6-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Principio Methodist</u>			
22d. LOCATION (City, town, or county) (State) <u>Principio, Cecil Co., Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>					
ADDRESS <u>North East, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12464

CERTIFICATE OF DEATH

12454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown Elkhon</u>		c. LENGTH OF STAY IN 1b <u>7 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Claude</u> Middle <u>E.</u> Last <u>Beldin</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 29, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Beldin</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>217-03-3253</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Parkinson's Disease, severe</u> DUE TO (c) <u>Arteriosclerosis, generalized, severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>Many years</u> <u>Many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 18</u> , 19 <u>59</u> , to <u>Nov 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 25</u> , 19 <u>59</u> , and that death occurred at <u>4:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Tillman D. Johnson</u>		ADDRESS (Street, city or town, state) <u>123 S. S. Ave., Elkhon, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u>		DATE SIGNED <u>Nov 30 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-28-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CHARLESTOWN METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>CHARLESTOWN, CEIL, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Frank</u>		ADDRESS <u>North East Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

CERTIFICATE OF DEATH

STATE OF NEW YORK  
COUNTY OF [illegible]

IN SENATE  
JANUARY 1, 1900

BEFORE ME, the undersigned authority, on this [illegible] day of [illegible], 1900,

presented for my certification the following

document, to-wit:

A [illegible] of [illegible] [illegible]

of the County of [illegible] and State of [illegible]

which document is a true and correct copy of the

original on file in my office.

IN WITNESS WHEREOF, I have hereunto set my hand and

affixed the Great Seal of the State, at [illegible] City,

this [illegible] day of [illegible], 1900.

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12477

## CERTIFICATE OF DEATH

12455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>		c. LENGTH OF STAY IN 1b <b>X</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BENJAMIN</b> Middle <b>FRANK</b> Last <b>BIGGS</b>		4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 28, 1875</b>
9. AGE (In years last birthday) yrs. <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Biggs</b>		14. MOTHER'S MAIDEN NAME <b>Susan Hessey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Raymond Biggs,</b>		Address <b>Cecilton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach with extension to liver</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>59</b> , to <b>Nov 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov 22</b> , 19 <b>59</b> , and that death occurred at <b>11:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D.		ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b> DATE SIGNED <b>22 NOV 59</b>	
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>		<b>Cecilton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 25, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cecilton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cecilton, Cecil Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		ADDRESS <b>Mullington, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12456

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Del.</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>3 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wyoming, D.1</b> <span style="float: right;">46X-3</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS <b>Wyoming Rd</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Isaac</b> First <b>Joshua</b> Middle <b>Bishop</b> Last				4. DATE OF DEATH Month <b>11</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-10-38</b>		9. AGE (In years last birthday) <b>21</b> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Magnolia, Del</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter F. Bishop</b>				14. MOTHER'S MAIDEN NAME <b>Rachel Shahan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>Navy</b>		17. INFORMANT Address <b>Mrs. Rachel Bishop, Wyoming, Del. R.D.1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed both sides of chest</b> 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car hit electric light pole</b>					
20c. TIME OF INJURY Month, Day, Year <b>2.10</b> a. m. <b>1114</b> p. m. <b>59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 282</b>		20f. (City or town) (County) (State) <b>Cecil, Cecil, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>11-14-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>17/Nov/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lake side</b>		22d. LOCATION (City, town, or county) (State) <b>over Del</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William E. T. ...</b>				24a. REC'D BY REGISTRAR <b>Nov 17 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. ...</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

**CERTIFICATE OF DEATH**

FILE NO.

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12457

12478

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b> c. LENGTH OF STAY IN 1b <b>2M 14D</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b> d. STREET ADDRESS <b>132 Fairmont Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>August</b> Middle <b>C</b> Last <b>BUCKHOLZ</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-15-88</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Jersey City, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>August Buckholz</b>		14. MOTHER'S MAIDEN NAME <b>Frieda Wagner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>VAH., Perry Point, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, lower lobes</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerosis, generalized, severe</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VAH. was deceased from</b> and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH., Perry Point, Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>J. L. Garey</b> M.D. PHYSICIAN'S NAME (Type) <b>J. L. GAREY, M.D.</b> CLINICAL PATHOLOGIST			
22a. BURIAL, CREMATION, or other disposition <b>buried</b>		22b. DATE THEREOF <b>11/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft Myers, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BENNINGTON &amp; SON</b> ADDRESS <b>Havre DeGrace, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 27 59</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>William S. Harris</b>			

STATEMENT OF WORK

12508

Project Title	Project Number	Project Status
Project Description	Project Dates	Project Location
Project Objectives	Project Budget	Project Personnel
Project Results	Project Evaluation	Project Conclusion



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12458

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil - MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 60 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 Bridge Street.		d. STREET ADDRESS 115 Bridge St -	
3. NAME OF DECEASED (Type or print) Murray Wilkerson		4. DATE OF DEATH Nov. 13 1959	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Baltimore Md	
13. FATHER'S NAME Davis Buncce		14. MOTHER'S MAIDEN NAME Mary Deal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		17. INFORMANT wife Bessie Draper Buncce	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 mo unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 13 1959, that I last saw the deceased alive on Nov 13 1959, and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE V. H. McKnight		DATE SIGNED 115 Bridge St - Elkton Md	
PHYSICIAN'S NAME (Type) V. H. McKnight			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-15-59	22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	22d. LOCATION (City, town, or county) (State) Elkton Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pippin Funeral Home Donald M. Dee Elkton, Md		24a. REC'D BY REGISTRAR DATE NOV 16 59	24b. REGISTRAR'S SIGNATURE Arthur S. Kane

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCASION OF DEATH <i>While on duty</i>		11. DATE OF BIRTH <i>Jan 15 1905</i>		12. PLACE OF DEATH <i>Home</i>	
13. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. NAME OF HOSPITAL <i>St. Mary's Hospital</i>		15. NAME OF NURSE <i>Miss M. Jones</i>	
16. NAME OF CORONER <i>Mr. W. B. Brown</i>		17. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		18. NAME OF MINISTER <i>Rev. J. H. Smith</i>	
19. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>		20. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		21. NAME OF MINISTER <i>Rev. J. H. Smith</i>	
22. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		23. NAME OF MINISTER <i>Rev. J. H. Smith</i>		24. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
25. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		26. NAME OF MINISTER <i>Rev. J. H. Smith</i>		27. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
28. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		29. NAME OF MINISTER <i>Rev. J. H. Smith</i>		30. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
31. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		32. NAME OF MINISTER <i>Rev. J. H. Smith</i>		33. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
34. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		35. NAME OF MINISTER <i>Rev. J. H. Smith</i>		36. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
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43. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		44. NAME OF MINISTER <i>Rev. J. H. Smith</i>		45. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
46. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		47. NAME OF MINISTER <i>Rev. J. H. Smith</i>		48. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
49. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		50. NAME OF MINISTER <i>Rev. J. H. Smith</i>		51. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
52. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		53. NAME OF MINISTER <i>Rev. J. H. Smith</i>		54. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
55. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		56. NAME OF MINISTER <i>Rev. J. H. Smith</i>		57. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
58. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		59. NAME OF MINISTER <i>Rev. J. H. Smith</i>		60. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
61. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		62. NAME OF MINISTER <i>Rev. J. H. Smith</i>		63. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
64. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		65. NAME OF MINISTER <i>Rev. J. H. Smith</i>		66. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
67. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		68. NAME OF MINISTER <i>Rev. J. H. Smith</i>		69. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
70. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		71. NAME OF MINISTER <i>Rev. J. H. Smith</i>		72. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
73. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		74. NAME OF MINISTER <i>Rev. J. H. Smith</i>		75. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
76. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		77. NAME OF MINISTER <i>Rev. J. H. Smith</i>		78. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
79. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		80. NAME OF MINISTER <i>Rev. J. H. Smith</i>		81. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
82. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		83. NAME OF MINISTER <i>Rev. J. H. Smith</i>		84. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
85. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		86. NAME OF MINISTER <i>Rev. J. H. Smith</i>		87. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
88. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		89. NAME OF MINISTER <i>Rev. J. H. Smith</i>		90. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
91. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		92. NAME OF MINISTER <i>Rev. J. H. Smith</i>		93. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
94. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		95. NAME OF MINISTER <i>Rev. J. H. Smith</i>		96. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
97. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		98. NAME OF MINISTER <i>Rev. J. H. Smith</i>		99. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	
100. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		101. NAME OF MINISTER <i>Rev. J. H. Smith</i>		102. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>	

TO BE FILLED BY THE REGISTRAR OF DEATHS

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF DEATH  
5. TIME OF DEATH  
6. PLACE OF DEATH  
7. CAUSE OF DEATH  
8. MANNER OF DEATH  
9. PLACE OF BIRTH  
10. OCCASION OF DEATH  
11. DATE OF BIRTH  
12. PLACE OF DEATH  
13. NAME OF PHYSICIAN  
14. NAME OF HOSPITAL  
15. NAME OF NURSE  
16. NAME OF CORONER  
17. NAME OF BURIAL PLACE  
18. NAME OF MINISTER  
19. NAME OF FUNERAL HOME  
20. NAME OF CEMETERY  
21. NAME OF MINISTER  
22. NAME OF FUNERAL HOME  
23. NAME OF CEMETERY  
24. NAME OF BURIAL PLACE  
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54. NAME OF FUNERAL HOME  
55. NAME OF CEMETERY  
56. NAME OF BURIAL PLACE  
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98. NAME OF FUNERAL HOME  
99. NAME OF CEMETERY  
100. NAME OF BURIAL PLACE  
101. NAME OF MINISTER  
102. NAME OF FUNERAL HOME

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12459

Reg. Dist. No.

<p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY <b>Cecil</b> MARYLAND</p>				<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</p> <p><b>Calvert</b></p>			<p>c. LENGTH OF STAY IN 1b</p> <p><b>2 yrs</b></p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</p> <p><b>North East R.D.</b></p>		
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p> <p><b>Graybeal Nursing Home</b></p>				<p>d. STREET ADDRESS</p>		<p>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p><b>3. NAME OF DECEASED</b> (Type or print)</p> <p>First <b>John</b> Middle <b>Chafchie</b> Last</p>				<p><b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>17</b> Year <b>1959</b></p>			
<p><b>5. SEX</b></p> <p><b>M</b></p>		<p><b>6. COLOR OR RACE</b></p> <p><b>W</b></p>		<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b></p> <p><b>1881</b></p>	
<p><b>9. AGE</b> (In years last birthday)</p> <p><b>78</b> yrs.</p>		<p><b>10. IF UNDER 1 YEAR</b></p> <p>Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.</p>		<p><b>11. BIRTHPLACE</b> (State or foreign country)</p> <p><b>Poland</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b></p> <p><b>Poland</b></p>	
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p> <p><b>Laborer</b></p>				<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b></p> <p><b>Farm</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country)</p> <p><b>Poland</b></p>	
<p><b>13. FATHER'S NAME</b></p> <p><b>no information</b></p>				<p><b>14. MOTHER'S MAIDEN NAME</b></p> <p><b>no information</b></p>			
<p><b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)</p> <p><b>no</b></p>		<p><b>16. SOCIAL SECURITY NO.</b></p> <p><b>no</b></p>		<p><b>17. INFORMANT</b> Address <b>Graybeal Nursing Home, Nottingham, Pa.</b></p>			
<p><b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]</p> <p><b>PART I. DEATH WAS CAUSED BY:</b></p> <p><b>IMMEDIATE CAUSE (a)</b> <b>Chronic Myocarditis</b></p> <p><b>422.2</b> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO</p> <p>(c) _____</p> <p><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b></p>							
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p><b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b></p>				<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p><b>20c. TIME OF INJURY</b> Month, Day, Year</p> <p>Hour <b>19</b> a. m. <b>19</b> p. m.</p>		<p><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)</p>		<p><b>20f. (City or town)</b> (County) (State)</p>	
<p><b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.</b></p>							
<p><b>ACTUAL SIGNATURE</b> <i>R. C. Dodson</i> M.D.</p>				<p><b>DATE SIGNED</b> <b>11-18-59</b></p>			
<p><b>EXAMINER'S NAME (Type)</b> <b>R. C. Dodson</b></p>				<p><b>DEPUTY MEDICAL EXAMINER</b> <b>11-18-59</b></p>			
<p><b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b></p> <p><b>Burial</b></p>		<p><b>22b. DATE THEREOF</b></p> <p><b>11-20-59</b></p>		<p><b>22c. NAME OF CEMETERY OR CREMATORY</b></p> <p><b>West Nottingham Cem.</b></p>		<p><b>22d. LOCATION (City, town, or county)</b> (State)</p> <p><b>Calvert Md.</b></p>	
<p><b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Vernon E. McPherson</i> ADDRESS <b>Rising Sun Md.</b></p>				<p><b>24a. REC'D BY REGISTRAR</b> DATE <b>NOV 20 '59</b></p>		<p><b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. K...</i></p>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 96

12460

12480

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Annes</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>14yrs.1mo.1days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>E.</b> Last <b>CONLEY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-31-94</b>
9. AGE (In years last birthday) <b>65</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel P. Conley</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Walls</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-10-0715</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized severe</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 15, 1945</b> , to <b>November 16, 1959</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>V.A. Hospital, Perry Point, Md. 11-16-59</b>			
ACTUAL SIGNATURE <b>J. L. GAREY</b>		PHYSICIAN'S NAME (Type) <b>Clinical Pathologist</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-18-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield</b>		22d. LOCATION (City, town, or county) (State) <b>Centreville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Barton Brothers, Centreville, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 19 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

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TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lewis Alexander Ewing		4. DATE OF DEATH Month 11 // Day 16 // Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1906
9. AGE (In years lost birthday) 53		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Farm Machinery	
11. BIRTHPLACE (State or foreign country) Cecil Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Elie Ewing		14. MOTHER'S MAIDEN NAME Lenna May Gibson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 218-03-1778	
17. INFORMANT Mrs. Dorothy Ewing, Colora, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7, 1958 to 11/16, 1959, that I last saw the deceased alive on 11/16, 1959, and that death occurred on 11/16 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Neil Taylor Jr.		DATE SIGNED 11/17/59	
PHYSICIAN'S NAME (Type) Neil Taylor Jr.		ADDRESS (Street, city or town, state) Rising Sun, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/1959	
22c. NAME OF CEMETERY OR CREMATORY Brookview Cem.		22d. LOCATION (City, town, or county) (State) Rising Sun Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Earl Tyson		24a. REC'D BY REGISTRAR DATE NOV 19 59	
ADDRESS Rising Sun Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12462

12467

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN lb <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u> d. STREET ADDRESS <u>X</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Willard</u> Middle <u>Brown</u> Last <u>Frederick</u>				<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>18</u> Year <u>1959</u>			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec. 30, 1893</u>		<b>9. AGE</b> (In years last birthday) <u>65</u> yrs. <b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Gravel Firm</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Wilmington, Del.</u>	
<b>13. FATHER'S NAME</b> <u>William Frederick</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ellen Walmsley</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>219-20-6299</u>		<b>17. INFORMANT</b> <u>Ann G. Frederick, 202 Medford R.D., Wilmington Del.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>R. C. Dodson</u>				<b>DATE SIGNED</b> <u>11-18-59</u>			
<b>EXAMINER'S NAME (Type)</b> <u>R. C. Dodson</u>				<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11-20-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Riverview Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Wilmington, Newcastle Co., Del.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph R. Grant North East md</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>NOV 23 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frame</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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1907-1908

1. *Introduction*

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12482

## CERTIFICATE OF DEATH

12483

Reg. Dist. No.

6

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>				c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna</b> First <b>Blanche</b> Middle <b>Gillespie</b> Last				4. DATE OF DEATH <b>Nov.</b> Month <b>19</b> Day <b>59</b> Year			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 // 22 // 1880</b>		9. AGE (In years lost birthday) yrs. <b>79</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retried</b>		11. BIRTHPLACE (State or foreign country) <b>Cecil Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Albert Boyd</b>				14. MOTHER'S MAIDEN NAME <b>Emma Catherine MacDowell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Nellie Weiser</b> <b>1128 S. Paxon St. Phila. 43, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <b>9</b> , 19 <b>59</b> , to <b>11/19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/19</b> , 19 <b>59</b> , and that death occurred at <b>11:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b> DATE SIGNED <b>11/20/59</b>							
ACTUAL SIGNATURE <b>Neil Taylor</b> M.D.				PHYSICIAN'S NAME (Type) <b>Rising Sun, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/22/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Colora Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tommy H. Muller</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



ISSUES CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. RACE White		4. DATE OF BIRTH 5/3/1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. DATE OF DEATH 4/4/68		7. PLACE OF DEATH Baltimore, Maryland		8. CAUSE OF DEATH Suicide		9. MANNER OF DEATH Homicide		10. ICD-9 CODE 276.21	
11. SIGNATURE OF DECEASED <i>James Earl Ray</i>		12. SIGNATURE OF WITNESS <i>James Earl Ray</i>		13. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		14. SIGNATURE OF CORONER <i>James Earl Ray</i>		15. SIGNATURE OF JURY <i>James Earl Ray</i>	
16. SIGNATURE OF DECEASED <i>James Earl Ray</i>		17. SIGNATURE OF WITNESS <i>James Earl Ray</i>		18. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		19. SIGNATURE OF CORONER <i>James Earl Ray</i>		20. SIGNATURE OF JURY <i>James Earl Ray</i>	
21. SIGNATURE OF DECEASED <i>James Earl Ray</i>		22. SIGNATURE OF WITNESS <i>James Earl Ray</i>		23. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		24. SIGNATURE OF CORONER <i>James Earl Ray</i>		25. SIGNATURE OF JURY <i>James Earl Ray</i>	
26. SIGNATURE OF DECEASED <i>James Earl Ray</i>		27. SIGNATURE OF WITNESS <i>James Earl Ray</i>		28. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		29. SIGNATURE OF CORONER <i>James Earl Ray</i>		30. SIGNATURE OF JURY <i>James Earl Ray</i>	
31. SIGNATURE OF DECEASED <i>James Earl Ray</i>		32. SIGNATURE OF WITNESS <i>James Earl Ray</i>		33. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		34. SIGNATURE OF CORONER <i>James Earl Ray</i>		35. SIGNATURE OF JURY <i>James Earl Ray</i>	
36. SIGNATURE OF DECEASED <i>James Earl Ray</i>		37. SIGNATURE OF WITNESS <i>James Earl Ray</i>		38. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		39. SIGNATURE OF CORONER <i>James Earl Ray</i>		40. SIGNATURE OF JURY <i>James Earl Ray</i>	
41. SIGNATURE OF DECEASED <i>James Earl Ray</i>		42. SIGNATURE OF WITNESS <i>James Earl Ray</i>		43. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		44. SIGNATURE OF CORONER <i>James Earl Ray</i>		45. SIGNATURE OF JURY <i>James Earl Ray</i>	
46. SIGNATURE OF DECEASED <i>James Earl Ray</i>		47. SIGNATURE OF WITNESS <i>James Earl Ray</i>		48. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		49. SIGNATURE OF CORONER <i>James Earl Ray</i>		50. SIGNATURE OF JURY <i>James Earl Ray</i>	
51. SIGNATURE OF DECEASED <i>James Earl Ray</i>		52. SIGNATURE OF WITNESS <i>James Earl Ray</i>		53. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		54. SIGNATURE OF CORONER <i>James Earl Ray</i>		55. SIGNATURE OF JURY <i>James Earl Ray</i>	
56. SIGNATURE OF DECEASED <i>James Earl Ray</i>		57. SIGNATURE OF WITNESS <i>James Earl Ray</i>		58. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		59. SIGNATURE OF CORONER <i>James Earl Ray</i>		60. SIGNATURE OF JURY <i>James Earl Ray</i>	
61. SIGNATURE OF DECEASED <i>James Earl Ray</i>		62. SIGNATURE OF WITNESS <i>James Earl Ray</i>		63. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		64. SIGNATURE OF CORONER <i>James Earl Ray</i>		65. SIGNATURE OF JURY <i>James Earl Ray</i>	
66. SIGNATURE OF DECEASED <i>James Earl Ray</i>		67. SIGNATURE OF WITNESS <i>James Earl Ray</i>		68. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		69. SIGNATURE OF CORONER <i>James Earl Ray</i>		70. SIGNATURE OF JURY <i>James Earl Ray</i>	
71. SIGNATURE OF DECEASED <i>James Earl Ray</i>		72. SIGNATURE OF WITNESS <i>James Earl Ray</i>		73. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		74. SIGNATURE OF CORONER <i>James Earl Ray</i>		75. SIGNATURE OF JURY <i>James Earl Ray</i>	
76. SIGNATURE OF DECEASED <i>James Earl Ray</i>		77. SIGNATURE OF WITNESS <i>James Earl Ray</i>		78. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		79. SIGNATURE OF CORONER <i>James Earl Ray</i>		80. SIGNATURE OF JURY <i>James Earl Ray</i>	
81. SIGNATURE OF DECEASED <i>James Earl Ray</i>		82. SIGNATURE OF WITNESS <i>James Earl Ray</i>		83. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		84. SIGNATURE OF CORONER <i>James Earl Ray</i>		85. SIGNATURE OF JURY <i>James Earl Ray</i>	
86. SIGNATURE OF DECEASED <i>James Earl Ray</i>		87. SIGNATURE OF WITNESS <i>James Earl Ray</i>		88. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		89. SIGNATURE OF CORONER <i>James Earl Ray</i>		90. SIGNATURE OF JURY <i>James Earl Ray</i>	
91. SIGNATURE OF DECEASED <i>James Earl Ray</i>		92. SIGNATURE OF WITNESS <i>James Earl Ray</i>		93. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		94. SIGNATURE OF CORONER <i>James Earl Ray</i>		95. SIGNATURE OF JURY <i>James Earl Ray</i>	
96. SIGNATURE OF DECEASED <i>James Earl Ray</i>		97. SIGNATURE OF WITNESS <i>James Earl Ray</i>		98. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		99. SIGNATURE OF CORONER <i>James Earl Ray</i>		100. SIGNATURE OF JURY <i>James Earl Ray</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12464

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Cecil</span> <span style="float: right;">12483</span> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="float: right;">c. LENGTH OF STAY IN 1b</span> North East River Beach Visiting d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Arundel Corp. property				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Cecil</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 249 Mackall Street 2/ d. STREET ADDRESS Elkton e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">Samuel</span> First <span style="font-size: 1.2em;">Raymond</span> Middle <span style="font-size: 1.2em;">Hague</span> Last			<b>4. DATE OF DEATH</b> <span style="font-size: 1.2em;">November</span> Month <span style="font-size: 1.2em;">12</span> Day <span style="font-size: 1.2em;">19</span> Year				
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">July 25, 1888</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">71</span> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Carpenter</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Cecilton, Maryland</span>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U. S. A.</span>				<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Samuel Edward Hague</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Mary Harris</span>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span>			
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">216-07-1789</span>		<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">Mrs. S. Raymond Hague, Elkton, Md.</span>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Accute Coronary Occusition</span> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <span style="font-size: 1.2em;">19</span>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">R. C. Dodson</span> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">R. C. Dodson, M. D.</span>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <span style="font-size: 1.2em;">Nov. 13, 1959</span>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">11/16/59</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Immaculate Conception</span>			
<b>22d. LOCATION (City, town, or county)</b> <span style="font-size: 1.2em;">Elkton, Maryland</span>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <span style="font-size: 1.2em;">Ralph E. Hicks, Elkton, Md.</span>			<b>24a. REC'D BY REGISTRAR</b> DATE <span style="font-size: 1.2em;">NOV 23 '59</span>		<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Arthur S. Frank</span>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
MEDICAL HISTORY [REDACTED]		PRESENT ILLNESS [REDACTED]		TREATMENT [REDACTED]	
PHYSICIAN'S SIGNATURE [REDACTED]		MEDICAL EXAMINER'S SIGNATURE [REDACTED]		COUNTY CLERK'S SIGNATURE [REDACTED]	
CITY OF BALTIMORE [REDACTED]		STATE OF MARYLAND [REDACTED]		COUNTY OF [REDACTED] [REDACTED]	



This certificate is to be filled out by the Medical Examiner of the County in which the death occurred. It is to be filed in the office of the County Clerk, and a copy is to be sent to the State Department of Health, Baltimore, Maryland.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film 6252 11-30-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12465

12484

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veteran's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JULIUS N HEYWARD</b>				4. DATE OF DEATH Month Day Year <b>November 17, 18, 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/4/24</b>	
9. AGE (In years lost birthday) yrs. <b>34</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>8-10 Wks</b>		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Charleston, S.C.</b>			
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JULIUS N. HEYWARD</b>				14. MOTHER'S MAIDEN NAME <b>BEATRICE SPENCER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>214-20-2669</b>			
17. INFORMANT <b>VAH., Perry Point, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelonephritis, bilateral, Severe</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myelitis, Chronic, at level of T-7</b> DUE TO <b>cause unknown</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>11/16/59</b> , 19 to <b>11/17/59</b> , 19, and that death occurred at <b>VAH., Perry Point, Md.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. L. Garey</b>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>				Clinical Pathologist.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11-23-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Balto nat cem</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE W KELSON</b>				24a. REC'D BY REGISTRAR <b>NOV 19 59</b>			
ADDRESS <b>1348 N. Calhoun St. Balto., Md.</b>				24b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

12482

1001

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1246S

CERTIFICATE OF DEATH

12466

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>156 W. Main</u>				d. STREET ADDRESS <u>1</u> <u>156 W. Main</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Herman</u> Last <u>Jeffers</u>				4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>19 59</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28 1876</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prop Resturant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Resturant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Herman Jeffers</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Cantwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>				16. SOCIAL SECURITY NO. <u>218-32-1316</u>			
INFORMANT <u>John E. Jeffers</u>				Address <u>Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE AZOTEMIA.</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>CHRONIC STARVATION</u> DUE TO (c) <u>CEREBRAL VASCULAR SCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>4 weeks</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8:20</u> , 19 <u>59</u> , to <u>11:1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11:1</u> , 19 <u>59</u> , and that death occurred at <u>3:15 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter Stavrakis</u>				ADDRESS (Street, city or town, state) <u>154 W. MAIN</u> DATE SIGNED <u>11.2.59</u>			
PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS M.D.</u>				<u>ELKTON</u> <u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H Walter duBois</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clifford S. Evans</u>			

CERTIFICATE OF DEATH

1948

1



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12469

## CERTIFICATE OF DEATH

Reg. Dist. No.

12467

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 205 Bow Street.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle W. Johnston Last		4. DATE OF DEATH Month Nov. Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpentry	
11. BIRTHPLACE (State or foreign country) Circleville, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Johnston		14. MOTHER'S MAIDEN NAME Catherine Phares	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-12-3627	
17. INFORMANT Mrs. Emma B. Johnston, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Cerebral Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH Oct 23-			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1949 to Nov. 9, 1959, that I last saw the deceased alive on Nov. 8, 1959, and that death occurred at 9:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. Nov. 10, 1959			
ACTUAL SIGNATURE Oneford H. Spence		PHYSICIAN'S NAME (Type) Cecil, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-59	
22c. NAME OF CEMETERY OR CREMATORY Calhoun		22d. LOCATION (City, town, or county) (State) Nr. Circleville, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		24a. REC'D BY REGISTRAR NOV 13 '59	
ADDRESS Dundon St. Elkton, Md.		24b. REGISTRAR'S SIGNATURE Cuthbert & Hanna	

CERTIFICATE OF DEATH

12168

MASSACHUSETTS

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

12168

MASSACHUSETTS

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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MASSACHUSETTS

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12485

## CERTIFICATE OF DEATH

Reg. Dist. No.

12468

1. PLACE OF DEATH a. COUNTY <b>CECIL COUNTY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Md.</b>		c. LENGTH OF STAY IN 1b <b>6Y-2M -2D</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Raspeburg, Balto. Md.</b>		03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Hospital</b>		d. STREET ADDRESS <b>608 Old Home Road.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILBUR J. LEPPER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/23/09</b>
9. AGE (In years lost birthday) yrs. <b>50</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACOB LEPPER</b>		14. MOTHER'S MAIDEN NAME <b>Mary McDonald</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>VAH., Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emphysema.</b> <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/9/53</b> , 19 <b>53</b> , to <b>11/11/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/11/59</b> , 19 <b>59</b> , and that death occurred at <b>2 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Perry Point, Md.</b> DATE SIGNED <b>11/11/59</b> ACTUAL SIGNATURE <b>Joseph H. Hooper</b> M.D. <b>Perry Point, Md.</b> PHYSICIAN'S NAME (Type) <b>JOSEPH H. HOOPER, MD.</b> <b>Perry Point, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/16/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>11/11/59</b>	
ADDRESS <b>6009 Harford Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12469

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barksdale</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barksdale, Elkton, R.D.</b>			
				d. STREET ADDRESS <b>/</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>J</b> Last <b>Mahoney</b>				4. DATE OF DEATH Month <b>11</b> Day <b>21</b> Year <b>19 59</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-16-1916</b>		9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Mahoney</b>				14. MOTHER'S MAIDEN NAME <b>Mary J. Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>William Mahoney, Elkton, R.D.Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>32 Caliber pistol wound below left nipple</b> <b>976x</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>through to the back.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot herself with 32 caliber revolver</b>			
20c. TIME OF INJURY Month, Day, Year <b>730 a. m. 11 21 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Elkton, R.D. Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R.C. Dodson</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>11-22-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-24-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East, Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph P. Grant</i>				ADDRESS <b>North East, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 24 '59</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

EDUCATION

RELATIONSHIP TO DECEASED

CAUSE OF DEATH

MANNER OF DEATH

DATE OF EXAMINATION

TIME OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF EXAMINATION

TIME OF EXAMINATION

PLACE OF EXAMINATION

NAME OF DECEASED

AGE

SEX

EDUCATION

RELATIONSHIP TO DECEASED

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MANNER OF DEATH

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TIME OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

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PLACE OF EXAMINATION

NAME OF DECEASED

AGE

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NAME OF EXAMINER

DATE OF EXAMINATION

TIME OF EXAMINATION

PLACE OF EXAMINATION

NAME OF DECEASED

AGE

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EDUCATION

RELATIONSHIP TO DECEASED

CAUSE OF DEATH

MANNER OF DEATH

DATE OF EXAMINATION

TIME OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

NAME OF DECEASED

AGE

SEX

EDUCATION

RELATIONSHIP TO DECEASED

CAUSE OF DEATH



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12470

## CERTIFICATE OF DEATH

Reg. Dist. No.

12470

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Irene</b> Middle <b>W.</b> Last <b>Moore</b>		4. DATE OF DEATH Month <b>11</b> Day <b>20</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1881</b>
9. AGE (In years lost birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. White</b>		14. MOTHER'S MAIDEN NAME <b>Katherine E. Birmingham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Barclay Moore Jr.</b>		Address <b>North East, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>420.1</b> DUE TO <b>Acute coronaru thrombosis</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>Arteriosclerosis ti c cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>7 da ys</b> <b>unknown n</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 1, 1959</b> to <b>November 20, 1959</b> , that I last saw the deceased alive on <b>November 20, 1959</b> , and that death occurred at <b>6:10a</b> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>233 E. Main St.</b> DATE SIGNED <b>11/20/59</b>	
PHYSICIAN'S NAME (Type) <b>S. Ralph Andrews, Jr., M.D.</b>		<b>Elkton, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-23-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>North East Cecil Co., Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>		ADDRESS <b>North East, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Adams</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

12471

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 Landing Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN THOMAS MOORE		4. DATE OF DEATH November 7 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY State Roads	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Moore		14. MOTHER'S MAIDEN NAME Annie Mc Neal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. John T. Moore		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Acute cerebrovascular accident 422.1 DUE TO Cerebrovascular accident -left hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 30 min. 5 yrs. unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 19 57, to Nov. 7 19 59, that I last saw the deceased alive on Nov. 7 19 59, and that death occurred at 12:35 a.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		ADDRESS (Street, city or town, state) 233 E. Main Street	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		DATE SIGNED 11/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 10, 1959	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald M. Lee Elkton, Md.		24a. REC'D BY REGISTRAR DATE NOV 12 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12472

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 27yrs.10mo.5days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 322 Willis	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES E. MUMFORD		4. DATE OF DEATH Month Day Year November 1 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-94
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Mumford		14. MOTHER'S MAIDEN NAME Emily Larimore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Bronchopneumonia, bilateral, unresolved DUE TO (b) Arteriosclerotic heart disease DUE TO (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.		INTERVAL BETWEEN ONSET AND DEATH 4-5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 27, 1931, to November 1, 1959, and that death occurred at 7:20p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J. L. Garey M.D. V.A. Hospital, Perry Point, Md. 11-3-59 PHYSICIAN'S NAME (Type) J. L. GAREY Clinical Pathologist			
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/5-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pennington & Son		24a. REC'D BY REGISTRAR DATE NOV 6 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

History

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12473

Reg. Dist. No.

12488

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE <b>Del.</b> b. COUNTY <b>New Castle</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, R.F.D.</b>				c. LENGTH OF STAY IN 1b <b>1 hour</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Md. Assembly Inc.</b>				d. STREET ADDRESS <b>6 Prospect Ave?</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>M</b> Last <b>Murphy</b>				4. DATE OF DEATH Month <b>11</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-18-1899</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plant Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Explosive</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Andrew Murphy</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth McHale</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>203-03-6809</b>		17. INFORMANT <b>Mrs. Mary C. Murphy, 6Prospect Ave. New Ark</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/12-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cem.</b>	
				22d. LOCATION (City, town, or county) <b>Newark, Del.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.T. Jones</b>				ADDRESS <b>Newark, Del</b>		24a. REC'D BY REGISTRAR <b>NOV 13 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Robert A. Frame</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12474

12489

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN lb <b>5 mo. 11 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Surf City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>67 x. 3</b> d. STREET ADDRESS <b>lagoon Drive, South</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALICE ELISE OSBORNE</b>		4. DATE OF DEATH Month Day Year <b>November 19 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-10-78</b>
9. AGE (In years last birthday) <b>80</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nursing</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Reg. Nurse</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Theodore B. Osborne</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Underhill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerosis, generalized, severe</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 8</b> , 19 <b>59</b> , to <b>November 19 1959</b> , and that death occurred at <b>7:00 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D.V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>11-20-59</b> ACTUAL SIGNATURE <b>J. L. Garey</b> PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b> <b>Clinical Pathologist</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>11/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Beverly National</b>		22d. LOCATION (City, town, or county) (State) <b>Beverly, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>		24a. REC'D BY REGISTRAR <b>Havre de Grace, Md.</b> DATE <b>NOV 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12475

12472

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 42 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles F. Rhodes		4. DATE OF DEATH Nov. 7 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1882
9. AGE (In years last birthday) 77		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Machinery	
11. BIRTHPLACE (State or foreign country) Marysville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Washington Rhodes		14. MOTHER'S MAIDEN NAME Sarah Ann Glossar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. No.	
17. INFORMANT Mr. Guy Rhodes, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Coronary Hemorrhage DUE TO (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Nov. 2, 1959		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 2, 1959, to Nov. 7, 1959, that I last saw the deceased alive on Nov. 7, 1959, and that death occurred at 8:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Melford H. Speckle M.D.		DATE SIGNED Nov. 7-59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-10-59	
22c. NAME OF CEMETERY OR CREMATORY Charlestown		22d. LOCATION (City, town, or county) (State) Charlestown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS 24a. REC'D BY REGISTRAR DATE NOV 13 '59	
24b. REGISTRAR'S SIGNATURE			

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12473 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>4 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union hospital</b>				/d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Almedia</b> Middle <b>H.</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>15th.</b> Year <b>19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 20th 1883</b>	
9. AGE (In years by birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>John Holden</b>				14. MOTHER'S MAIDEN NAME <b>Adranna Bennet</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Holden Moore</b>		Address <b>Aberdeen Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive cerebrovascular accident</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>senility</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>  <b>years.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12 Nov</b> , 19 <b>59</b> , to <b>Nov. 15th</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 15th</b> , 19 <b>59</b> , and that death occurred at <b>315 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cecilton Md.</b> DATE SIGNED <b>16 Nov 59</b> ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D. PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/18/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Warwick Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Warwick Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. L. Smith</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 18 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12490

## CERTIFICATE OF DEATH

Reg. Dist. No.

12477

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Aikin Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Lackland</b> Last <b>Taylor</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1874</b>
9. AGE (In years last birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>telegraph operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O, R R</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Eleanora Jackson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Morton Taylor, Perryville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis -</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arterio-Sclerosis -</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>7/4/56</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April-17, 1959</b> to <b>Nov. 25, 1959</b> , that I last saw the deceased alive on <b>Nov. 25, 1959</b> , and that death occurred at <b>6:15 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clarence I. Benson</b> M.D.		DATE SIGNED <b>11-27-1959</b>	
PHYSICIAN'S NAME (Type) <b>Clarence I. Benson, M.D.</b>		ADDRESS (Street, city or town, state) <b>Port Deposit, Md.</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-29-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham, Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Colora, Md. Rural</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leola Patterson</b>		24a. REC'D BY REGISTRAR <b>NOV 30 59</b>	
ADDRESS <b>Perryville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hance</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the burial-transit permit from the certificate and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12478

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Del.</b> b. COUNTY <b>New Castle</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS <b>228 W. Main</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Harry D. Thompson</b>				4. DATE OF DEATH Month <b>11</b> Day <b>3</b> Year <b>59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-28-01</b>		9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trucker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>		11. BIRTHPLACE (State or foreign country) <b>Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Silas Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Agnus Grant</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>222-07-3065</b>		17. INFORMANT <b>Mrs. Harry Thompson, 228 W. Main St. Middletown</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Old Fellows Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Myers Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. F. Daniels</b>				24a. REC'D BY REGISTRAR <b>NOV 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALT MORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF MEDICAL EXAMINER [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF CORONER [Illegible]	
CERTIFICATE OF DEATH [Illegible]		CERTIFICATE OF DEATH [Illegible]		CERTIFICATE OF DEATH [Illegible]	



This certificate is to be filled out by the Medical Examiner of the County or City in which the death occurred. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland. The Medical Examiner is to be a physician or surgeon, or a person qualified by the Department of Health. The Registrar is to be a person qualified by the Department of Health. The Department of Health is to be the State Department of Health, Baltimore, Maryland.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12491

CERTIFICATE OF DEATH

12479

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PERRY POINT</b>		c. LENGTH OF STAY IN 1b <b>3yrs5mos25days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>843 Carroll Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>HENRY</b> Last <b>WALKER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 21, 1894</b>
9. AGE (In years last birthday) <b>64</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES WALKER</b>		14. MOTHER'S MAIDEN NAME <b>ALICE TERRELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-1</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records, VA Hospital, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia, bilateral</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>490X</b> DUE TO (c) <b>490X</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Approx. 2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 10, 1956</b> to <b>November 4, 1959</b> , and that death occurred at <b>10:30 AM</b> from the causes and on the date stated above.		DATE SIGNED <b>11-5-59</b>	
ACTUAL SIGNATURE <b>A. Bernardo</b>		ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>A. BERNARDO</b>		Asst. Chief, Surgical Service	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>11-9-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>		ADDRESS <b>Havre DeGrace, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

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CERTIFICATE OF DEATH

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# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12492

## CERTIFICATE OF DEATH

Reg. Dist. No.

12480

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>			
c. LENGTH OF STAY IN 1b <u>years.</u>				d. STREET ADDRESS <u>Summit Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>B</u> Last <u>Watson</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1880</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GOVT.</u>		11. BIRTHPLACE (State or foreign country) <u>Chesapeake City, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George R Watson</u>				14. MOTHER'S MARDEN NAME <u>Henrietta Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>109-20-1607</u>			
INFORMANT <u>LAURA L. WATSON</u> Address <u>CHES. CITY, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>156.1 Carcinoma of Liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>156.1</u> DUE TO (c) <u>156.1</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Phlebo thrombosis &amp; pulmonary embolism.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>59</u> , to <u>Nov 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 9</u> , 19 <u>59</u> , and that death occurred at <u>4:00</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D.				ADDRESS (Street, city or town, state) <u>Cecil, Md</u> DATE SIGNED <u>11 Nov 59</u>			
PHYSICIAN'S NAME (Type) <u>WALLACE OBENSHAIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NR. CHESAPEAKE CITY, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FOXERL HOME DONALDSON</u> ADDRESS <u>ELATON, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 18 '59</u> DATE			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

12101

NAVY AND MARINE CORPS - DEPARTMENT OF THE NAVY

12101

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12493

CERTIFICATE OF DEATH

12481

Reg. Dist. No 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN lb <b>7 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Hill</b>		17x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>ELWOOD</b> Last <b>WESSEL</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-27-03</b>
9. AGE (In years lost birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR: Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Storekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Wessel</b>		14. MOTHER'S MAIDEN NAME <b>Lena Story</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>215-14-3917</b>	
INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neoplasm, left lobe of brain, (Temporal)</b> 193.0 DUE TO (b) <b>Type undetermined.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>VA</b> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 17, 1959</b> to <b>November 24, 1959</b> and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>R. H. Twining</b> M.D. <b>V.A. Hospital, Perry Point, Md. 11-25-59</b> PHYSICIAN'S NAME (Type) <b>R. H. TWINING</b> <b>V.A. Medical Service.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Nov. 27</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Church Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Church Hill, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar Lane Funeral Home, Church Hill, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>			

100

2010-11-29

1990

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97034: 210015

125

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MSF-11-315

### MAX Alcohol: Less than 1

1000

3275



12494

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Pennsylvania</b> b. COUNTY <b>Westmoreland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Youngwood</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VA Hospital, Perry Point, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH W. WOTTCZAK</b> Middle <b>JOSEPH W. WOTTCZAK</b> Last <b>JOSEPH W. WOTTCZAK</b>		4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10, 1892</b>
9. AGE (In years last birthday) <b>67</b>		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brewery Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Wottczak</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Nellie Micholobie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records, VAH - Perry Point, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized, severe</b> DUE TO (c) <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>VA</b> 19 p. m. <b>VA</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>deceased</del> <b>deceased</b> <del>on</del> <b>on</b> <del>at</del> <b>at</b> <del>and that death occurred at</del> <b>and that death occurred at</b> <b>5:00AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH., Perry Point, Maryland</b> DATE SIGNED <b>11-18-59</b>			
ACTUAL SIGNATURE <b>J. L. Garvey</b>		PHYSICIAN'S NAME (Type) <b>J. L. GARVEY, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL, OR OTHER DISPOSITION <b>Removal</b>		22b. DATE THEREOF <b>11-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Youngwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Youngwood, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>		24a. REC'D BY REGISTRAR <b>Havre DeGrace Md. NOV 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

12493

County of ...

State of ...

Dec. 1, 1901

County of ...

V. ...

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